LONG-TERM CARE HOSPITALS PAYMENT SYSTEM

*payment***basics**

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Patients with chronic critical illness—those who exhibit metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often ongoing respiratory failure—frequently need hospital-level care for relatively extended periods. Nationwide, most chronically critically ill (CCI) patients are treated in acute care hospitals, but some are admitted to long-term care hospitals (LTCHs). These facilities can be freestanding or co-located with other hospitals as hospitals-within-hospitals (HWHs) or satellites. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for its Medicare patients. Medicare payments to LTCHs were about $5.5 billion in 2012; Medicare beneficiaries accounted for about two-thirds of these hospitals' revenues. In 2012, about 124,000 Medicare beneficiaries had about 140,000 discharges from LTCHs, and 420 facilities were Medicare certified.[1] LTCHs are not distributed evenly through the nation.

Beneficiaries transferred to an LTCH from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$1,216 in 2014—as the first admission during a spell of illness. An additional copayment is required if the beneficiary's hospital stay (whether in an acute care hospital, an LTCH, or combined) extends beyond 60 days during a spell of illness. In 2014, the copayment is $304 per day for the 61st through 90th days. Beneficiaries treated in LTCHs are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[2]

Since October 2002, Medicare has paid LTCHs predetermined per discharge rates based primarily on the patient's diagnosis and market area wages. Before then, LTCHs were paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed a facility-specific limit that was adjusted annually.

Under the PPS, discharges are assigned to case-mix groups containing patients with similar clinical problems that are expected to require similar amounts of resources. Each case-mix group has a national relative weight reflecting the expected costliness of treatment for a patient in that category compared with that for the average LTCH patient.

Defining the long-term care hospital product Medicare buys

Under the LTCH prospective payment system (PPS), Medicare pays for the operating and capital costs associated with hospital inpatient stays in LTCHs. Medicare sets per discharge payment rates for different case-mix groups called Medicare severity long-term care diagnosis related groups (MS–LTC–DRGs) based on the expected relative costliness of treatment for patients in the group. Patients are assigned to these groups based on their principal diagnosis, secondary diagnoses, procedures performed, age, sex, and discharge status. The MS–LTC–DRGs are the same groups used in the acute inpatient PPS but have relative weights specific to LTCH patients, reflecting the average relative costliness of cases in the group compared with that for the average LTCH case.[3]

Setting the payment rates

The PPS payment rates cover all operating and capital costs that LTCHs would be expected to incur in furnishing covered services. The initial payment level (base rate) for a typical discharge in fiscal year 2015 is $41,044. Payments to LTCHs that

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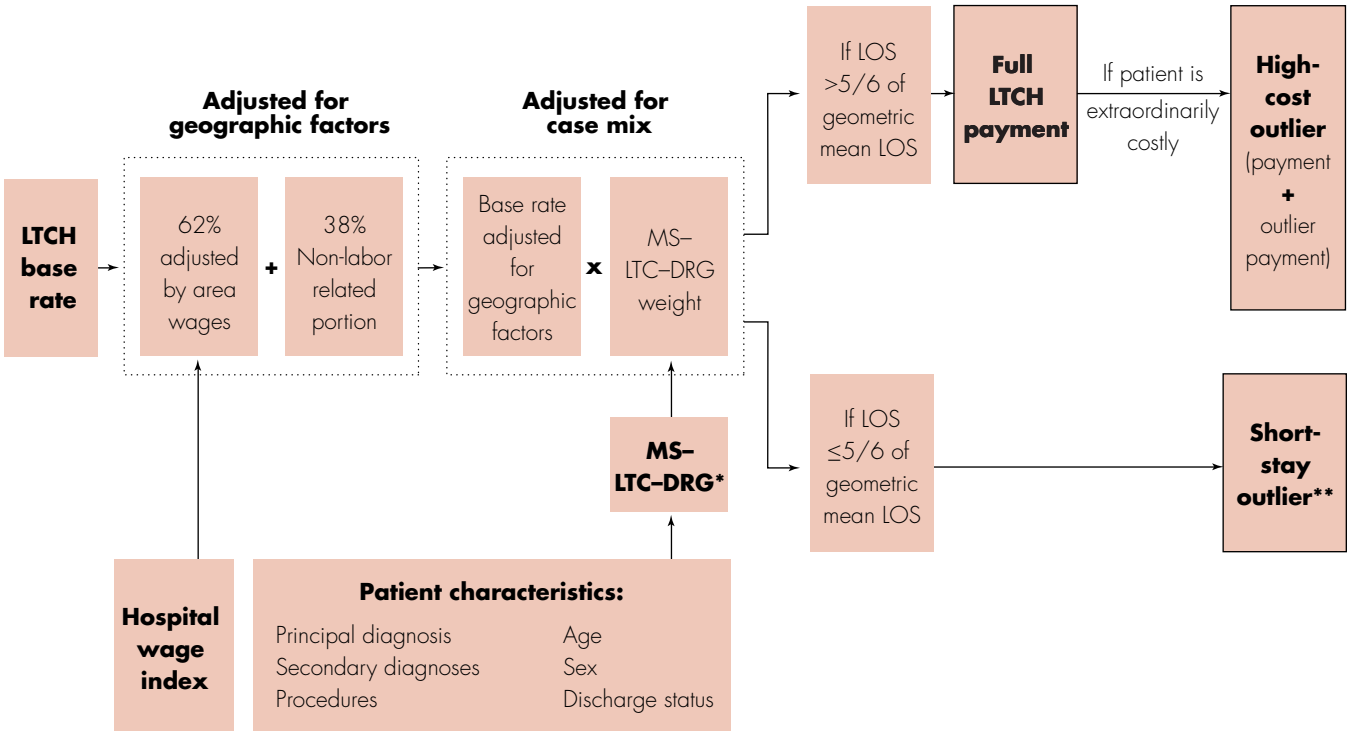
Figure 1 Long-term care hospital prospective payment system



Note: LTCH (long-term care hospital), MS–LTC–DRG (Medicare severity long-term care diagnosis related group), LOS (length of stay).
* MS–LTC–DRGs comprise base DRGs subdivided into one, two, or three severity levels.
** Payments generally are reduced for short-stay patients.

fail to provide data on specified quality indicators are reduced by 2 percent.

The base rate is adjusted to account for differences in market area wages (Figure 1). The labor-related portion of the base payment amount—62 percent—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion.[4] For LTCHs in Alaska and Hawaii, the nonlabor portion is adjusted by a cost of living adjustment (COLA) and added to the labor-related portion.[5] The adjusted rate for each market is multiplied by the relative weights for all MS–LTC–DRGs to create local PPS payment rates.

Short-stay outliers—LTCHs are paid adjusted PPS rates for patients who have short stays. Short-stay outliers (SSOs) are cases with a length of stay up to and including five-sixths of the geometric average length of stay for the MS–LTC–DRG. For SSOs, LTCHs are paid the least of:

- 100 percent of the cost of the case,
- 120 percent of the MS–LTC–DRG specific per diem amount multiplied by the length of stay for that case,
- the full MS–LTC–DRG payment, or
- an amount that is a blend of the inpatient PPS amount for the MS–DRG and the 120 percent of the LTCH per diem payment amount. As the length of stay for the SSO increases, the portion of payment attributable to the LTCH per diem increases.

Medicare applies a different standard for the shortest SSO cases. These cases are those in which length of stay is less than or equal to the average length of stay for the same MS–DRG at acute care hospitals paid under the inpatient PPS (IPPS) plus one standard deviation. For very short-stay

cases that meet this "IPPS comparable threshold," LTCHs are paid the least of:

- 100 percent of the cost of the case,
- 120 percent of the LTC–DRG specific per diem amount multipled by the length of stay for that case,
- the full LTC–DRG payment, or
- the IPPS per diem amount multiplied by the length of stay for the case, not to exceed the full IPPS payment amount.[6]

High-cost outliers—LTCHs are paid outlier payments for patients who are extraordinarily costly. High-cost outlier cases are identified by comparing their costs to a threshold that is the MS–LTC–DRG payment for the case plus a fixed loss amount. In FY 2015 the fixed loss amount is $14,972. Medicare pays 80 percent of the LTCHs' costs above the threshold. High-cost outlier payments are funded by reducing the base payment amount for all LTCHs by 8 percent.

Interrupted stays—LTCHs receive one payment for "interrupted-stay" patients. An interrupted stay is when an LTCH patient is discharged to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF), stays for a specified period, then goes back to the same LTCH. The specified period of time is 9 days for an acute care hospital, 27 days for an IRF, and 45 days for a SNF. Any LTCH discharge readmitted within three days is also considered an interrupted stay.

The 25 percent rule

The 25 percent rule reduces payments for LTCHs that exceed established percentage thresholds for patients admitted from certain referring hospitals during a cost-reporting period. The rule is intended to help ensure that LTCHs do not function as units of acute care hospitals and that decisions about admission, treatment, and discharge in both acute care hospitals and LTCHs are made for clinical rather than financial reasons.

When first implemented, the 25 percent rule applied only to LTCH hospitals within hospitals (HWHs) and satellites, limiting the proportion of Medicare patients who could be admitted from a HWH's or satellite's host hospital during a cost reporting period. The policy was phased in over three years, with the threshold for most HWHs and satellites set at 75 percent for fiscal year 2006, 50 percent for fiscal year 2007, and 25 percent for fiscal year 2008. (Less stringent thresholds are applied to HWHs and satellites in rural areas or in urban areas where they are the sole LTCH or where there is a dominant acute care hospital.) After the threshold is reached, the LTCH is paid the lesser of the LTCH PPS rate or an amount equivalent to the acute care hospital PPS rate for patients discharged from the host acute care hospital.[7] Patients from the host hospital who are outliers under the acute hospital PPS before their transfer to the HWH do not count toward the threshold and continue to be paid at the LTCH PPS rate even if the threshold has been reached.

Beginning in July 2007, CMS expanded the 25 percent rule to apply to all freestanding LTCHs, limiting the proportion of patients who can be admitted to an LTCH from any one acute care hospital during a cost reporting period. The extended policy was to be phased in over three years, with the applicable threshold for non-HWHs and nonsatellites set at 75 percent for rate year 2008.

The Medicare, Medicaid, and SCHIP Extension Act of 2007—as amended by the Patient Protection and Affordable Care Act of 2010 (PPACA), the Health Care Education Reconciliation Act of 2010, and the Pathway for SGR Reform Act of 2013—substantially changed the implementation of the 25 percent rule. Together, these laws roll back the phased-in implementation of the 25 percent rule for HWHs and satellites to 50 percent and prevent application of the rule to freestanding LTCHs for a total of nine years. In addition, The Pathway for SGR Reform Act of 2013 also permanently exempts certain co-located LTCHs from the 25 percent rule.

"Site-neutral" payments

Beginning in fiscal year 2016, Medicare will pay differently for some cases in LTCHs. Under the Pathway for SGR Reform Act of 2013, Medicare will pay "site-neutral" rates, based on what Medicare pays for similar cases in acute care hospitals, unless the LTCH case had an immediately preceding acute care hospital stay and (a) that stay included at least three days in an intensive care unit or (b) the LTCH discharge receives a principal diagnosis indicating the receipt of mechanical ventilation services for at least 96 hours. All other LTCH discharges will be paid an amount based on Medicare's acute care hospital payment rates under the inpatient prospective payment system or 100 percent of the costs of the case, whichever is lower.

Payment updates

There is no mechanism in law for updating payments to LTCHs. CMS has stated that it intends to update LTCH PPS payment rates based on the most recent estimate of an LTCH-specific market basket index (which measures the price increases of goods and services LTCHs buy to produce patient care). PPACA requires that any annual update to the LTCH payment rates beginning in fiscal year 2012 be reduced by an adjustment for productivity. PPACA also requires that the any update is further reduced by an additional adjustment through 2019. ■

1 Medicare beneficiaries enrolled in Medicare Advantage plans are not included in these aggregate totals.

2 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$608 per day in 2014.

3 MS–LTC–DRGs with fewer than 25 cases are grouped into 5 categories based on their average charges; relative weights for these 5 case-mix groups are determined based on the average charges for the MS–LTC–DRGs in each of these groups.

4 The wage index used to adjust LTCH payments is calculated from wage data reported by acute care hospitals without the effects of geographic reclassification.

5 The COLA is intended to reflect the higher costs of supplies and other nonlabor resources in Alaska and Hawaii. It increases the nonlabor portion of the payment by as much as 25 percent.

6 The policy for very short-stay cases was first implemented in July 2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007, as amended by the Patient Protection and Affordable Care Act, provided for a 5-year moratorium on the application of the policy.

7 During the year, the HWH will be paid the LTCH rate. During retrospective settlement at the end of an HWH's cost report year, if the HWH is determined to be overpaid, CMS will collect the overpayments from future payments.